Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

OCCUPATIONAL HEARING LOSS QUESTIONNAIRE

Name	Claim Number	Injury Date

1. When did you first notice your hearing loss?

2. Was the onset of the hearing loss: ❑ sudden ❑ gradual

3. What kind(s) of hearing problems are you having? (Circle letter of all applicable items.)
   - A. Ringing in ears?
   - B. Difficulty hearing on the phone?
   - C. Difficulty hearing spoken communication in one-to-one conversation?
   - D. Difficulty understanding spoken communication in the presence of surrounding noise?
   - E. Other – Explain:

4. While employed, did your hearing loss interfere with your work? ❑ Yes ❑ No
   If yes, how?

4a. Did your employer or union conduct hearing tests? ❑ Yes ❑ No

5. Name & address of doctor who told you your hearing loss was occupational:
   Doctor's name
   Address
   City State ZIP+4

6. How were you notified?
   - ❑ Written (If notified in writing, please attach a copy)
   - ❑ Oral
   - ❑ Other (Please specify):

7. Have you been examined by any other doctor in the past for hearing loss:
   ❑ Yes ❑ No If yes, please provide:

   Doctor's name | Exam date | Audiogram done? ❑ Yes ❑ No
   Address
   City State ZIP+4

   Doctor's name | Exam date | Audiogram done? ❑ Yes ❑ No
   Address
   City State ZIP+4

8. When you were first told by a doctor that your hearing loss was caused by work noise, did he/she also tell you that you should have:
   - A. Medical Treatment? ❑ Yes ❑ No
     If yes, what kind of treatment?
   - B. A Hearing Aid ❑ Yes ❑ No
   - C. Did you have an audiogram? ❑ Yes ❑ No

9. Have you ever had hearing aids in the past? ❑ Yes ❑ No
   If yes, when? Month Year

   Doctor/Clinic name
   Address
   City State ZIP+4

10. Do you have a health problem for which you must take medication on a regular basis? ❑ Yes ❑ No
    If yes, what is the health problem, and what kind of medication are you taking?

11. Name & address of doctor prescribing your medications
    Doctor's name
    Address
    City State ZIP+4

12. Have you had any injury to your ear(s)? ❑ Yes ❑ No
    If yes, please describe the injury:

13. Have you had any illness that affected your ears or hearing? ❑ Yes ❑ No
If yes, please indicate when and name of illness.

14. Have you ever had a head injury? ❑ Yes ❑ No
If yes, please describe the injury:

15. Have you had any illness involving high fever? ❑ Yes ❑ No
If yes, please indicate when and what illness:

HEALTH HISTORY

16. Have any members of your family suffered hearing loss?
❑ Yes ❑ No If yes, specify relationship (i.e., mother, father, aunt , uncle):

UNION INVOLVEMENT

17. Were you a member of a union or trade when exposed to noise that you think contributed to your hearing loss?
❑ Yes ❑ No If yes, which union:

NON-WORK NOISE EXPOSURE

18. Do you have any hobbies of non-work activities which involve loud noise such as: (Check all that apply)

- ❑ Loud Music
- ❑ Auto Repair
- ❑ Woodworking
- ❑ Metal Working
- ❑ Wood Cutting
- ❑ Snowmobiling
- ❑ Motorbiking
- ❑ Boating
- ❑ Hunting/Target practicing
- ❑ Auto Racing
- ❑ Flying aircraft
- ❑ Operate Noisy Equipment such as:
  - ❑ Tractors
  - ❑ Farm Equipment
  - ❑ Lawn Mowers
- ❑ Other – please specify:

19. Type of equipment or tools used for hobbies: How often? How long (time duration?)

Please list any hobbies or activities you participate in that involve noise.

OTHER

20. Current or last rate of pay?
Amount $
Select rate ❑ Hour ❑ Day ❑ Week ❑ Month

21. Are you retired? ❑ Yes ❑ No
A. If yes, why did you retire?

B. If you are retired, what is the last date you worked when you were exposed to noise that you think contributed to your hearing loss?
Month Year

C. Did you have a hearing test as any part of a physical exam even when you retired?
❑ Yes ❑ No

22. Was your employer contributing to your and/or your family's medical, dental and/or vision insurance on the last date you worked when exposed to noise that you think contributed to your hearing loss? ❑ Yes ❑ No

23. Today's date:_____ Signature:_____